LOUISIANA STATE BOARD OF MEDICAL EXAMINERS
(LSBME)
Main Phone: (504) 568-6820 (auto attendant)

ALLIED HEALTH
(OTHER THAN CLINICAL LABORATORY PERSONNEL)

APPLICATION AND INSTRUCTIONS

(Rev. 051705)

Visit the LSBME website at www.lsbme.louisiana.gov

Application Processing Addresses:
LSBME, P.O. Box 54403, New Orleans, LA 70154-4403

Criminal Background Check Address:
LSBME, ATTN.: CB, P. O. Box 30250, New Orleans, LA 70190-0250

Physical Address:
630 Camp Street, New Orleans, LA 70130

PART II:
INSTRUCTIONS FOR
ALLIED HEALTH PROFESSIONS OTHER THAN
CLINICAL LABORATORY PERSONNEL

GENERAL INSTRUCTIONS

See "Examination Contacts for Medical and Allied Health Professions Other Than Clinical Laboratory Personnel" to request that an examination scores report is forwarded *by the examiner* directly to the LSBME, Office of Licensure, P.O. Box 30250, New Orleans, LA 70130.

ATHLETIC TRAINER

To be eligible and qualified for certification, an applicant shall:

1. be at least 18 years of age;
2. be a citizen of the United States or possess valid and current legal authority to reside and work in the United States duly recognized and issued by the commissioner of the Immigration and Naturalization Service of the United States under and pursuant to the Immigration and Nationality Act and the commissioner's regulations thereunder;
3. possess at least one of the following educational qualifications:
    a. have successfully completed and graduated from an athletic training program of curriculum at a college or university approved by the board; or
    b. possess a degree in physical therapy issued by a school, college, or university approved by the board; have successfully completed a basic athletic training course; a first-aid course approved by the American Red Cross, a cardiopulmonary resuscitation course approved by the American Heart Association or the American Red Cross, and a nutrition course; have been associated for not less than two years with an athletic team; demonstrate proficiency in athletic care; and possess letters of recommendation from a physician and a certified athletic trainer; or
    c. possess a college or university diploma; have successfully completed not less than three consecutive (military duty excepted) and four total years employment or service as an apprentice athletic trainer at a college or university under the direct supervision of a state certified or licensed athletic trainer; and have successfully completed courses in athletic training, first-aid, cardiopulmonary resuscitation, and nutrition at an accredited college or university;
4. take and successfully pass the written and/or oral certification examination administered by the board or by the NATA or its successor;
5. satisfy the applicable fees;
6. satisfy the procedures and requirements for application and, if applicable, the procedures and requirements for examination; and
7. not be otherwise disqualified for certification by virtue of the existence of any grounds for denial of certification as provided by the law or in these rules.

The burden of satisfying the board as to the qualifications and eligibility of the applicant for certification shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by and to the satisfaction of the board.

Checklist

- Original or 8 1/2" x 11" photocopy of diploma for degree in athletic training ***or*** original or certified copy of diploma for degree in physical therapy, including basic athletic training course
    - First aid course
    - CPR course
    - Nutrition course
- Letter evidencing not less than two years association with an athletic team.
- Passing scores on the NATA (National Athletic Trainer Association) exam.
- 1 recent photograph
- Character recommendations: See description under "Character Recommendations".
- See discussion of birth certificates and passports herein.
- Criminal Background Check Materials

CLINICAL EXERCISE PHYSIOLOGIST

To be eligible for a license, an applicant shall:

1. be at least 21 years of age;
2. be of good moral character;
3. be a citizen of the United States or possess a valid and current legal authority to reside and work in the United States, duly issued by the commissioner of Immigration and Naturalization of the United States under and pursuant to the Immigration and Nationality Act and the commissioner's regulations thereunder;
4. have successfully completed a Masters of Science degree or a Master of Education degree in an exercise studies curriculum at an accredited school, which school at the time of the applicant's graduation, was approved by the American College of Sports Medicine or the board;
5. be certified by as an exercise specialist by the American College of Sports Medicine (ACSM), having taken and successfully passed the ACSM certifying examination or RCEP examination, as administered by ACSM or by the board pursuant to Subchapter D of these rules; and
6. have successfully completed an internship of 300 hours in exercise physiology under the supervision of a licensed exercise physiologist.

The burden of satisfying the board as to the qualifications and eligibility of the applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by, and to the satisfaction of, the board.

In addition to the substantive qualifications specified, to be eligible for a license, an applicant shall satisfy the procedures and requirements for application and the procedures and requirements for examination.

Checklist

- Original or 8 1/2" x 11" photocopy of Diploma for degree of Masters of Science or Master of Education from school approved by the American College of Sports Medicine or LSBME.
- Certificate as an exercise specialist by the American College of Sports Medicine (ACSM).
- Passing scores on ACSM or RCEP examination.
- 1 recent photograph.
- Criminal Background Check Materials.
- See discussion of birth certificates and passports herein.

MIDWIFE

To be eligible for licensure as a licensed midwife, an applicant shall:

1. be at least 21 years of age and shall have graduated from high school;
2. be a citizen of or lawfully authorized to reside and be employed in the United States;
3. be currently certified in basic cardiopulmonary resuscitation (CPR);
4. have demonstrated competence in the basic sciences of human anatomy, human physiology, biology, psychology, and nutrition in the manner prescribed;
5. have completed a course of study in the theory of pregnancy and childbirth;
6. have met, within four years prior to the date of application, the following requirements for practical clinical experience prescribed;
7. have demonstrated professional competence in the practice of midwifery by passing an examination administered by the board; and
8. cause to be submitted to the board four written recommendations of the applicant for licensure, one by a physician or certified nurse-midwife, one by a licensed midwife, one by a consumer of midwifery services, and one by a member of the community in which the applicant resides.

The burden of satisfying the board as to the qualifications and eligibility of the applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by and to the satisfaction of the board.

Checklist

- Proof of certification in CPR.
- Proof of courses taken in human anatomy, human physiology, biology, psychology, biology, psychology, nutrition, and theory of pregnancy and childbirth.
- Proof of practical clinical experience.
- Passing scores on NARM (National Association of Registered Midwives) Examination.
- 1 recent photograph.
- Criminal Background Check Materials.
- Character recommendations: See description under “Character Recommendations”.
- See discussion of birth certificates and passports.

OCCUPATIONAL THERAPIST / ASSISTANT

To be eligible for a license, an applicant shall:

1. be of good moral character;
2. be a citizen of the United States or possess valid and current legal authority to reside and work in the United States duly issued by the commissioner of the Immigration and Naturalization Service of the United States under and pursuant to the Immigration and Nationality Act and the commissioner's regulations thereunder;
3. have successfully completed the academic and supervised field work experience requirements to sit for the "Certification Examination for Occupational Therapist, Registered" or the "Certification Examination for Occupational Therapy Assistant" as administered or contracted for by the American Occupational Therapy Association, Inc. (AOTA);
4. make written application to the board for review of proof of his current certification by the AOTA on a form and in such a manner as prescribed by the board;
5. file a written application for licensure on a form provided by the board;
6. have taken and successfully passed the licensing examination required by the board.

The burden of satisfying the board as to the qualifications and eligibility of the applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by, and to the satisfaction of, the board.

In addition to the substantive qualifications specified, to be eligible for a license, an applicant shall satisfy the procedures and requirements for application provided and the procedures and requirements for examination provided.

Checklist

- Passing scores on the “Certification Examination for Occupational Therapist, Registered”/Certification Examination for Occupational Therapy Assistant as administered by the National Board for Certification in Occupational Therapy or proof of registration for exam, if applying for a Temporary Permit.
- 1 recent photograph.
- Criminal Background Check Materials
- Character recommendations: See description under “Character Recommendations”.
- See discussion of birth certificates and passports herein.
- Contact LSBME for fees for verification of licensure, if reciprocity application.

PHYSICIAN ASSISTANT

To be eligible for licensure as a Physician Assistant, an applicant shall:
be at least 20 years of age;
be of good moral character;
demonstrate his competence to provide patient services under the supervision and direction of a supervising physician by:

- presenting to the board a valid diploma certifying that the applicant is a graduate of a physician assistant training program accredited by the Committee on Allied Health Education and Accreditation (CAHEA), or its successors, and by presenting or causing to be presented to the board satisfactory evidence that the applicant has successfully passed the national certification examination administered by the National Commission on Certificate of Physician Assistants (NCCPA) or its successors, together with satisfactory documentation of current certification;
  or
- presenting to the board a valid, current physician assistant license, certificate or permit issued by any other state of the United States; provided, however, that the board is satisfied that the certificate, license or permit presented was issued upon qualifications and other requirements substantially equivalent to the qualifications and other requirements set forth by the LSBME; certify that he is mentally and physically able to engage in practice as a physician assistant;
  as of the date of application or the date on which it is considered by the board, be subject to discipline, revocation, suspension, or probation of certification or licensure in any jurisdiction for cause resulting from the applicant's practice as a physician assistant; provided, however, that this qualification may be waived by the board in its sole discretion.

Checklist

- Original or 8 1/2" x 11" photocopy of diploma from Physician Assistant training program accredited by the Committee on Allied Health Education and Accreditation (CAHEA).
- Passing scores on certification examination administered by National Commission on Certificate of Physician Assistants (NCCPA).
- Documentation of Current certification by NCCPA.
- 1 recent photograph.
- Criminal Background Check Materials
- Character recommendation: See description under "Character Recommendations".
- See discussion of birth certificates and passports herein.
- Contact LSBME for fees for verification of licensure, if reciprocity application.

PRIVATE RADIOLOGICAL TECHNOLOGIST

To be eligible for certification as a Private Radiological Technologist, an applicant shall:

1. be at least 18 years of age;
2. be of good moral character;
3. have successfully completed a four-year course of study in a secondary school approved by the State Board of Elementary and Secondary Education, passed an approved equivalency test, or have graduated from a secondary school outside Louisiana having comparable approval;
4. have attended and successfully completed a course of radiological study and safety which meets the requirements, or have been employed by a physician continuously since September 1, 1983 to perform diagnostic or therapeutic radiological examinations or treatments or both in the private office or clinic of that physician and under said physician's direct supervision.

An applicant shall have attended and successfully completed an educational program and formal training meeting either of the following standards in preparation for the position of radiologic technologist prior to making application for certification.

An educational program and formal training that meets the essentials and guidelines of an accredited educational program for the radiographer, radiation therapy technologist, and the nuclear medicine technologists as adopted by the American College of Radiology, American Medical Association, and the American Society of Radiologic Technologists and is accredited by the Committee on Allied Health Education and Accreditation and the Joint Review Committee on Education in Radiologic Technology shall be deemed adequate. The adequacy of such program shall exist only during the term within which it remains accredited by the aforesaid accrediting entities.

A specific course of radiological study and safety approved by the board and attended and completed by a potential applicant within the six months prior to making application.

Checklist

- Proof of completion of an education program approved by the American College of Radiologist Technologists and accredited by Committee on Allied Health Education and Accreditation and the Joint Review Committee on Education in Radiologic Technology.
- Proof of completion of a specific course of radiological study and safety approved by the LSBME.
- 1 recent photograph.
- Criminal Background Check Materials
- Character recommendation: See description under "Character Recommendations".
- See discussion of birth certificates and passports herein.

RESPIRATORY THERAPIST

Registered Respiratory Therapist

To be eligible and qualified to obtain a registered respiratory therapist license, an applicant shall:

1. be at least 18 years of age;
2. be of good moral character;
3. be a high school graduate or have the equivalent of a high school diploma;
4. possess current credentials as a registered

respiratory therapist granted by the National Board of Respiratory Care, or its successor organization or equivalent approved by the board, on the basis of written examination; or show proof of registration for exam if applying for a Temporary License.

5. be a citizen of the United States or posses valid and current or legal authority to reside and work in the United States duly issued by the Commissioner of Immigration and Naturalization Service of the United States under pursuant to the Immigration and Nationality Act and the commissioner's regulations thereunder;
6. satisfy the applicable fees as prescribed by the LSBME;
7. satisfy the procedures and requirements for application provided; and
8. not be otherwise disqualified for licensure by virtue of the existence of any grounds for denial of licensure as provided by the law.

The burden of satisfying the board as to the qualifications and eligibility of the applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualification in the manner prescribed by and to the satisfaction of the board.

Checklist

- Original High School Diploma or Official Transcript from High School.
- Possess current credentials as a registered respiratory therapist granted by the National Board of Respiratory Care.
- Passing scores on examination administered by NBRC exam, or proof of registration for exam, if applying for a Temporary Permit.
- 1 recent photograph.
- Criminal Background Check Materials.
- Character recommendation: See description under "Character Recommendations".
- See discussion of birth certificates and passports herein.

Certified Respiratory Therapist

To be eligible and qualified to obtain a certified respiratory therapist license, an applicant shall:

1. be at least 18 years or age;
2. be of good moral character;
3. be a high school graduate or have the equivalent of a high school diploma;
4. have successfully completed:
   a. a traditional respiratory care education program then accredited by the Commission on Accreditation of Allied Health Education Programs, or its successor, in collaboration with the Committee on Accreditation for Respiratory Care; or
   b. a nontraditional respiratory care education program then accredited by the Commission on Accreditation of Allied Health Education Programs, or its successor, in collaboration with the Committee on Accreditation for Respiratory Care;
5. possess at least one of the following credentials
   a. current credentials as a certified respiratory therapist granted by the National Board for Respiratory Care, or its successor organization or equivalent approved by the board, on the basis of written examination; or
   b. have taken and successfully passed the examination administered by the board; provided, however, that an applicant who has failed such examination four times shall not thereafter be eligible for licensure in Louisiana; or
   c. a temporary license and who has taken and passed the licensing examination administered by the board; provided, however, that an applicant who has failed such examination four times shall not thereafter be eligible for licensure in Louisiana;
6. be a citizen of the United States or posses valid and current or legal authority to reside and work in the United States duly issued by the Commissioner of Immigration and Naturalization Service of the United States under pursuant to the Immigration and Nationality Act and the commissioner's regulations thereunder;
7. satisfy the applicable fees;
8. satisfy the procedures and requirements for application and if applicable, the procedures and requirements for examination; and
9. not be otherwise disqualified for licensure by virtue of the existence of any grounds for denial of licensure as provided by law.

The burden of satisfying the board as to the qualifications and eligibility of the applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualification in the manner prescribed by and to the satisfaction of the board.

Checklist

- Original High School Diploma or Official Transcript from High School.
- Proof of Completion of traditional respiratory care education program, approved by Commission on Accreditation of Allied Health Education Programs ***or*** a non-traditional respiratory care program approved by the Commission on Accreditation of Allied Health Education Programs.
- Original or certified copy of Credentials as a certified respiratory therapist granted by the National Board for Respiratory Care.
- Passing scores on examination administered by National Board for Respiratory Care or proof of registration for exam, if applying for a Temporary Permit.
- Character recommendation: See description under "Character Recommendations".
- Criminal Background Check Materials
- See discussion of birth certificates and passports herein.

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

FEE SCHEDULE FOR ALLIED HEALTH

(Rev 050104)

Initial Licensure Fees

Note: If applying for a temporary permit, permanent licensure fee must accompany the temporary permit fee.

Profession		Form Of Payment	Payable To	Amount	Send To	*Total*
ALL APPLICANTS: ***FINGERPRINTS***		Money Order	La. Department of Public Safety and Corrections	$50.00	LSBME	$50.00
For LSBME to return documents to applicant in U.S. by U.S. Certified Mail, Return Receipt Requested.		Check or Money Order	LSBME	$2.55	LSBME	$
For LSBME to return documents to applicant in U.S. by courier.		***SEE INSTRUCTIONS***				----------
ALLIED HEALTH (other than clinical Laboratory)						
	Athletic Trainer	Check or Money Order	LSBME	$125.00	LSBME	$
	Athletic Trainer Temporary Permit	Check or Money Order	LSBME	$50.00	LSBME	$
	Clinical Exercise Physiologist	Check or Money Order	LSBME	$150.00	LSBME	$
	Midwife	Check or Money Order	LSBME	$200.00	LSBME	$
	Midwife Apprentice Permit	Check or Money Order	LSBME	$100.00	LSBME	$
	Midwife Senior Apprentice Permit	Check or Money Order	LSBME	$100.00	LSBME	$
	Occupational Therapist	Check or Money Order	LSBME	$150.00	LSBME	$
	Occupational Therapy Assistant	Check or Money Order	LSBME	$100.00	LSBME	$
	Occupational Therapy Temporary Permit	Check or Money Order	LSBME	$50.00	LSBME	$
	Occupational Therapy Assistant Temporary Permit	Check or Money Order	LSBME	$50.00	LSBME	$
	Physician Assistant	Check or Money Order	LSBME	$250.00	LSBME	$
	Physician Locum Tenens	Check or Money Order	LSBME	$25.00	LSBME	$
	Physician Asst., Supervising Physician (One time fee)	Check or Money Order	LSBME	$75.00	LSBME	$
	Private Radiological Technologist	Check or Money Order	LSBME	$35.00	LSBME	$
	Registered Respiratory Therapist (RRT)	Check or Money Order	LSBME	$150.00	LSBME	$
	RRT Work Permit	Check or Money Order	LSBME	$50.00	LSBME	$
	RERT Temporary License	Check or Money Order	LSBME	$200.00	LSBME	$
	Certified Respiratory Therapist (CRT)	Check or Money Order	LSBME	$100.00	LSBME	$
	CERT Temporary License	Check or Money Order	LSBME	$150.00	LSBME	$
	CRT Work Permit	Check or Money Order	LSBME	$50.00	LSBME	$
TOTAL						**$**

NOTE: The LSBME will notify applicant if insufficient monies are remitted.

Renewal Fees[1]

All disciplines below due on or before the first (1st) day of licensee's birth month		
Discipline	**Scheduled Renewal Fee**	**If After First (1st) Day of Your Birth Month**
Registered Respiratory Therapist	$100.00	
Certified Respiratory Therapist	$75.00	
Occupational Therapist & Assistants	$100.00 / $75.00	$125.00 / $100.00
Clinical Exercise Physiologist	$100.00	$125.00
Physicians Assistant	$150.00	

The Following Dates And Fees Apply To Midwives And Athletic Trainers Only			
Discipline	**Due Date**	**Scheduled Renewal Fee**	**Late Renewal Fee** ***(Penalty Fee + Renewal Fee)***
Midwives	March 31	$200.00	$250.00
Athletic Trainers	June 30	$125.00	

[1] Fees are not prorated (i.e. License received mid year fee payable in full, next annual renewal payable in full)

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS—New Orleans, Louisiana

Allied Health Application for Initial Permit/License/Certification-- **It is unlawful to file false public records in any public office or with any public official.** ***Refer to the application instructions when completing these forms. Carefully prepare responses.***

(Rev. 051705)

Area for Licensure, Permitting, Registration and/or Certification
Check all that apply. Specify the purpose and discipline of licensure application. Type or block print only. Do not use felt-tip pens.

CHECK ALL THAT APPLY!

____ Occupational Therapy/Assistant ____Midwifery ____Physician Assistant

____Registered Respiratory Therapy ____Certified Respiratory Therapy ____ Athletic Trainers

____Private Radiological Technology ____Clinical Exercise Physiology

____ Licensure by endorsement ***Do you also need:*** ____Temporary Permit

____Temporary License

1. Name(s) — Use *full* name. Do not use initials or nicknames unless they are part of your legal name. Line 1: Surname (including Jr., Sr., II, etc.) and degree; Line 2: First and Middle Name(s). If name is hyphenated, include the hyphen. List your name as it appears on each document.

1a. License, Permit, Registration, and/or Certification—This Is Your Legal Name. This is the name that will be printed on your license, permit, certification and/or registration used for all reporting and on inquiries. Use this name on each page of the application.

1b. Medical/Professional Diploma.

1c. Internship. Include name and location of hospital(s). On line 3, state name of hospital and location.

1d. NAOMA, NATA, ACSM, NARM, NCCPA, NBCOT and NBRC Certificate(s). Specify certificate by placing "X" in appropriate blank.

1e. State License(s), Permit, Registration and/or Certification. Identify State.

1f. Certificate of Naturalization, Declaration of Intention, Valid Visa Specify.

1g. All Other Alternate Names—Include ***all*** other names and nicknames (including names used for/in the following: National Boards and Board Actions).

Statement of Legal Name:
Sworn Before a Notary

1a. _____
_____

1b. _____
_____

1c. _____
_____
_____
Hospital and Location

1d. _____
_____

____NATA ____ACSM ____NARM ____NCCPA ____NBOT ____NBRC ____RCEP
____Other (specify): _____

Certificate Number: _____

1e. _____
_____

_____
State

1f. _____
_____

1g. _____
_____

Statement of Legal Name

I understand that the Louisiana State Board of Medical Examiners maintains all records in alphabetical order and that I will be listed alphabetically under my surname (last name) as stated in Item 1a of this Application.

_____
Signature

Subscribed and sworn on this _____ day of _____, in the year 200____.

_____
Notary Public

_____
My Commission Expires

SEAL

Insert Name: Same as 1a

2. Personal Interview

State the preferred location for personal interview with original credentials. Personal interview shall not be made until application is otherwise complete.

If does not apply, mark "X" here: ☐

PA
☐New Orleans ☐Shreveport ☐Baton Rouge ☐Morgan City ☐Lafayette

OT
☐Alexandria ☐Lafayette ☐Baton Rouge ☐Shreveport ☐New Orleans
☐Monroe ☐Lake Charles

ATH
☐Broussard ☐Covington ☐Hammond ☐Lafayette ☐Monroe
☐New Orleans ☐Ruston

3. Addresses

Address ***must*** include physical address (i.e. street number, street name). If applicable, include apartment number with physical address.

3a. Mailing—This is the address to which correspondence will be forwarded by the LSBME.
*This is the address that will appear in the *LSBME Official List* and will be provided to the public.

It is your responsibility to keep the LSBME apprised of all address changes.

3b. Permanent--If same as mailing address, mark "X" here: ☐

3c. Business Address
This is NOT the MAILING or PERMANENT addresses listed in items 3a and 3b.

3a. _____
Physical Address

_____
Post Office Box (if applicable)

_____
City Parish/County State Zip/Postal Code plus 4

_____
Country, if not U.S.

3b. _____
Physical Address

_____
Post Office Box (if applicable)

_____
City Parish/County State Zip/Postal Code plus 4

_____
Country, if not U.S.

3c. _____
Physical Address

_____
Post Office Box (if applicable)

_____
City Parish/County State Zip/Postal Code plus 4

_____
Country, if not U.S.

4. Telephone Numbers

International Country Code _____

_____ - _____ Ext. _____ _____ - _____
Business Phone Home Phone

_____ - _____ _____ - _____
Business Fax Home Fax

_____ - _____ Ext. _____ _____ - _____
Cell Phone Pager

5. Website and E-mail Address(es)

List primary and secondary e-mail addresses, if applicable.

_____
Website Address

_____
Primary E-mail Address

_____
Secondary E-mail Address (if applicable)

Insert Name: Same as 1a	
6. Date and Place of Birth Notarized birth certificate or passport required. If passport submitted, explain on separate 8 ½ "x 11" sheet of paper.	_____ _____ _____ Month Day Year _____ City Parish/County State (US only) _____ Province/Territory _____ Country
7. Nationality/ Citizenship If not native born U.S. citizen (born in U.S. or one of its territories), proof of U.S. citizenship or valid visa issued by U.S. Immigration and Naturalization required. Proof of U.S. citizenship can be by producing an *original* certificate of naturalization or certificate of birth to U.S. citizens traveling abroad. A valid visa is a visa issued by the Immigration and Naturalization Service authorizing a person to reside and work in the U.S. *No license or temporary permit for practice in Louisiana will be issued without production of above credentials.*	a. Are you an U.S. Citizen? ☐ Yes ☐ No b. If not native born citizen of the U.S., provide following: Type VISA: _____ If naturalized, provide certificate number: _____ INS number: _____ Petition number: _____ Date issued: _____ District Court through which issued: _____ Certificate of Citizenship certificate number: _____
8. Identification Numbers	_____ - _____ - _____ _____ _____ U.S. Social Security Number Driver's License Number Issuing State _____ National Identification Number _____ Issuing Country
9. Gender	_____ Male _____Female
10. Physical Description See Instructions for LSBME Code Descriptions. Use linear measure in feet and inches.	Height _____ Weight _____ Eyes _____ Hair _____ Race _____ Ft. In. Lbs. Color Color Optional ____I have no physical mark(s). ____I have the following physical mark(s): _____ Description of Mark Location _____ Description of Mark Location
11. Military U.S. Active Duty	Have you ever served in the U.S. Military? ☐Yes ☐No *If yes,* Branch _____ Dates served _____Type Discharge _____

Insert Name: Same as 1a	
12. License/Permit/ Registration / Certification History List States in which you obtained a License, Permit, Registration and/or Certification. Specify type, license number and date initially issued. Include ***all*** licenses, whether permanent or temporary. Does not apply, mark here ☐	Louisiana _____ Date _____ Other States: _____ Date_____ _____ Date_____ _____ Date_____ _____ Date_____

To order criminal background materials, e-mail the LSBME here: **lsbmemat@lsbme.louisiana.gov**. ***Include the following information: Name, Mailing Address and Telephone Number.***

CONTINUE TO THE NEXT PAGE

Insert Name: Same as 1a	
13. Third-Party Authorization	***THIRD PARTY AUTHORIZATION*** I understand and acknowledge that the submission of an application to, as well as the acceptance or maintenance of, any license, permit, certificate and/or registration (hereinafter referred to as a "license") issued by the Louisiana State Board of Medical Examiners (the "Board") shall constitute and operate as a perpetual authorization by me to each educational institution at which I have matriculated, each state or federal agency to which I have applied for any license, permit, certificate and/or registration, each person, firm, corporation, clinic, office or institution by whom or with whom I have been employed in the practice of medicine or as an allied health professional, each physician or other health care practitioner whom I have consulted or seen for diagnosis or treatment and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Board any and all information and documentation concerning me which the Board may deem material to the consideration of my initial application and during such period as I may hold or maintain a license. With respect to any such information or documentation, the submission of an application to or the acceptance or maintenance of a license from the Board shall equally constitute and operate as a consent by me to the disclosure and release of such information and documentation and as a waiver by me of any privilege or right of confidentiality which I would otherwise possess with respect thereto. By submitting an application or accepting or maintaining a license issued by the Board, I shall be deemed to have given my consent to submit to physical or mental examinations if, when and in the manner so directed by the Board and to have waived all objections as to the admissibility or disclosure of findings, reports or recommendations pertaining thereto on the grounds of privileges provided by law. I acknowledge that the expense of any such examination shall be borne by me. The submission of an application or the acceptance or maintenance of a license from the Board shall also constitute and operate as perpetual authorization and consent by me to the Board to disclose and release any information or documentation set forth in or submitted with my application, or which then or at any time thereafter may be obtained by the Board from other persons, firms, corporations, associations or governmental entities, to any person, firm, corporation, association or governmental entity having a lawful, legitimate and reasonable need therefor, including, without limitation, the medical and/or allied health professional licensing, permitting, certifying and/or registering authority of any state; the Federation of State Medical Boards of the United States; professional organizations, associations and societies; the American Medical Association and any component state, county or parish medical society, including but not limited to the Louisiana State Medical Society and component parish societies thereof; the American Osteopathic Association; the Louisiana Osteopathic Medical Association; the Federal Drug Enforcement Agency; the Louisiana Office of Narcotics and Dangerous Drugs, Office of Licensing and Registration, Department of Health and Hospitals; federal, state, county or parish and municipal health and law enforcement agencies and the Armed Services. I understand that this authorization and consent is valid commencing on the date herein below subscribed and that such will remain in force and effect until and unless I withdraw my application for, or no longer possess or maintain, a license issued by the Board. I also acknowledge that a duplicate of this document may serve as an original. Signature: _____. Full Name ****TO BE SIGNED IN THE PRESENCE OF A NOTARY** Subscribed and sworn to before me this _____ day of _____, 20_____. _____ Notary Public ***Seal*** MY COMMISSION EXPIRES: _____

Insert Name: Same as 1a	
14. Blank By Design.	BLANK
15. Examination History-Allied Health Professions Provide the most recent examination date and total number of attempts for each examination you have taken for purposes of state medical licensure, permit, certification and/or registration. Incorrectly reported examinations will result in delays.	**If does not apply, mark "X" here:** ☐

Examination Sponsor		**Most Recent Attempt (Month/Year)**	**No. of Attempts**	**State Board**
Athletic Trainers	**NATA**	_____	_____	_____
Clinical Exercise Physiologist	**ACSM**	_____	_____	_____
	RCEP	_____	_____	_____
Midwife or Apprentice	**NARM**	_____	_____	_____
Occupational Therapist/Asst.	**NBCOT**	_____	_____	_____
Physician Assistant	**NCCPA**	_____	_____	_____
Certified or Registered Respiratory Therapist	**NBRC**	_____	_____	_____
	CRT	_____	_____	_____
	RRT (written)	_____	_____	_____
	RRT (Clinical Sims)	_____	_____	_____

Signature: _____ Date: _____

Insert Name: Same as 1a

16. Pre Allied Health Education

List high school and all colleges and/or universities you attended **prior** to allied health school in chronological order, most recent listed first.

You may photocopy this page to report more than four (4) institutions, if necessary.

Account for **ALL** time since high school. If a break of six (6) months or more occurred during the attendance dates you provide, report the beginning and ending dates of this break at 17B. It is not necessary to report breaks between institutions.

Note:
LSBME does not verify allied health education (except in cases where credits were granted towards the degree.) The information provided will be reported exactly as it appears on this page.

Name of Institution #1

Address

City State

Country Zip Code Plus 4

From Month Day Year To: Month Day Year Degree: ☐None ☐B.A. ☐B.S. ☐M.A. ☐M.S. ☐High School ☐ Other: _____

Was any part of this education used as credit towards your medical degree? ☐Yes ☐No

Name of Institution #2

Address

City State

Country Zip Code Plus 4

From Month Day Year To: Month Day Year Degree: ☐None ☐B.A. ☐B.S. ☐M.A. ☐M.S. ☐High School ☐ Other: _____

Was any part of this education used as credit towards your medical degree? ☐Yes ☐No

Name of Institution #3

Address

City State

Country Zip Code Plus 4

From Month Day Year To: Month Day Year Degree: ☐None ☐B.A. ☐B.S. ☐M.A. ☐M.S. ☐High School ☐ Other: _____

Was any part of this education used as credit towards your medical degree? ☐Yes ☐No

Name of Institution #4

Address

City State

Country Zip Code Plus 4

From Month Day Year To: Month Day Year Degree: ☐None ☐B.A. ☐B.S. ☐M.A. ☐M.S. ☐High School ☐ Other: _____

Was any part of this education used as credit towards your medical degree? ☐Yes ☐No

Insert Name: Same as 1a

17A. Allied Health Education

If does not apply, mark "X" here: ☐

List all of the allied health schools attended in chronological order, beginning with most recent school attended.

Photocopy this page to report more than two (2) institutions, if necessary.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8 ½" x 11" sheet of paper. Your response may not exceed 100 words per question.

DOCUMENTATION:

Include a legible photocopy of allied health school diploma. Provide a complete mailing address.

Complete Name of Institution # 1 (Do Not abbreviate)

Street Address, City, State, Country (if not U.S.), Zip Code

Beginning Month / Date / Year — Month / Date / Year Graduated

_____Degree _____Did Not Graduate

Unusual Circumstances (check Yes or No)

Did you take a leave(s) of absence or break(s) from your allied health education? ..... ☐Yes ☐No

Were you ever placed on probation? ..... ☐Yes ☐No

Were you ever disciplined or placed under investigation? ..... ☐Yes ☐No

Were any negative reports ever filed against you? ..... ☐Yes ☐No

Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason? ..... ☐Yes ☐No

Please explain each "Yes" response from above:

Complete Name of Institution # 2 (Do Not Abbreviate)

Street Address, City, State, Country (if not U.S.), Zip Code

Month / Date / Year Commenced — Month / Date / Year Graduated

_____Degree _____Did Not Graduate

Unusual Circumstances (check Yes or No):

Did you take a leave(s) of absence or break(s) from your allied health education? ..... ☐Yes ☐No

Were you ever placed on probation ..... ☐Yes ☐No

Were you ever disciplined or placed under investigation? ..... ☐Yes ☐No

Were any negative reports ever filed against you? ..... ☐Yes ☐No

Were any limitations or special requirements imposed on you because of Academic incompetence, disciplinary problems or for any other reason? ..... ☐Yes ☐No

Please explain each "Yes" response from above:

17B. Practice History and Non-Professional Activity

(Do NOT include Training) Account for ALL time, in chronological order, from High School to the present.

From Month/Year	To Month Year	Location City/State	Employer/Practice	Specialty/Activity

Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250
Telephone: (504) 568-6820

OATH OR AFFIRMATION

Answer the following questions
(Yes answers must be explained in sworn affidavit *-AFFIDAVIT MUST BE TYPED!*)

	YES	NO
1. In the five years prior to this application, have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession?		
2. In the five years prior to this application, have you been addicted to or used in excess any drug or chemical substance including alcohol or treated through a drug or alcohol rehabilitation program?		
3. Have you ever, either as an adult or juvenile, been cited, arrested, charged, convicted or pled nolo contendere to, violation of any: a) State statute?		
b) Federal statute?		
4. Has your application for examination or license ever been rejected or denied?		
5. Have you ever failed a licensure/certification examination? If yes, how many times?_____		
6. Have you ever been denied membership in a state, county, or local professional society?		
7. Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?		
8. Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished, staff or clinical privileges in any hospital or other health care institution or organization?		
9. Have you had any malpractice claims filed, settled or adjudicated against you within the last five (5) years?		
10. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?	**N/A**	**N/A**
11. Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?		
12. Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?		
13. Have you ever agreed not to seek re-licensure in any licensing jurisdiction?		
14. Have you ever been, or are you currently in the process of being denied, terminated, suspended, refused, limited, placed on probation or placed under other disciplinary action with respect to your participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)?		
15. Has any court determined you are currently in violation of a court's judgment or order for the support of dependent children?		

OATH OR AFFIRMATION OF APPLICANT

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe, abide by and uphold the laws of the State of Louisiana governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from immoral, unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

Signed _____
Full Name

Subscribed and sworn to before me this _____day

of_____YEAR_____

_____
NOTARY PUBLIC

My commission expires_____

Louisiana State Board of Medical Examiners
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Website: **www.lsbme.louisiana.gov**

CERTIFICATE OF PROGRAM CHAIRMAN/HEAD

APPLICANT'S NAME

_____

SOCIAL SECURITY NUMBER

_____

***Section 1: To Applicant*—**Complete Section 1 before a Notary. Forward this form to your Program Chairman/Head of Allied Health School for completion.

Recent photograph

Passport quality photograph of Applicant securely affixed. 2" x 2" clear, front view, full face without hat or dark glasses. Full-length photograph, black and white or computer-generated will not be accepted. Applicant is to sign name across bottom of photograph, partly on photograph and partly upon the page.

Notary is to affix seal directly on photograph.

Affix Photograph Here
(Follow directions carefully.)

I certify that the photograph is a true likeness of _____ (Applicant).

On this the _____Day of _____, 200_____

_____
Notary Public

My commission expires_____

Section 2: To Program Chairman/Head

After completion of this form, return to Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT RETURN TO APPLICANT.

I hereby certify that _____

Whose photograph appears above, was awarded the degree of, or certificate in, _____

Dated _____from this school.

_____ _____
Name of school/program Signature of Medical Dean/Registrar, Allied Program Chairman/Head

_____ _____
Address Title

_____
Date

Affix School Seal Here

Louisiana State Board of Medical Examiners

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Telephone: (504) 568-6820
Website: www.lsbme.louisiana.gov

To be completed if applying based on reciprocity

VERIFICATION / ENDORSEMENT

Section 1: To Applicant— Complete Section 1 of this form and forward it to the licensing agency of each state in which you have ever obtained licensure/certification, whether permanent or temporary. If necessary, this form may be duplicated.

I hereby authorize the licensing agency of the State of _____to release all information on file concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

_____ _____
TYPE OR PRINT YOUR FULL NAME SIGNATURE

_____ _____
LICENSE NUMBER AND DATE ISSUED ADDRESS

_____ _____
SOCIAL SECURITY NUMBER CITY, STATE, ZIP CODE

Section 2: **THE SECTION BELOW IS TO BE COMPLETED BY THE VERIFYING/ENDORSING STATE** ***and returned to the Louisiana State Board of Medical Examiners, P.O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.***

A. This is to certify that the records of the licensing Board of the State of _____indicate that the above-named individual was issued license/certificate No._____ dated_____ on the basis of written examination (state name of examination)_____; reciprocity with the state of _____; other basis (please name)_____.

B. *If State Board Examination*, provide statement of grades or attach hereto.

C. Provide the following:

1. Is this license/certificate current? ..... ☐Yes ☐No ☐Cannot Divulge
2. Is this license/certificate in good standing? ..... ☐Yes ☐No ☐Cannot Divulge
3. Has this individual ever been warned or reprimanded? ..... ☐Yes ☐No ☐Cannot Divulge
4. Has this individual license/certificate ever been revoked? ..... ☐Yes ☐No ☐Cannot Divulge
5. Has this individual license/certificate ever been suspended? ..... ☐Yes ☐No ☐Cannot Divulge
6. Has this individual license/certificate ever been placed on probation? ..... ☐Yes ☐No ☐Cannot Divulge
7. Has this individual license/certificate ever been restricted in any manner? ..... ☐Yes ☐No ☐Cannot Divulge
8. Has this individual ever had any charges filed against him/her? ..... ☐Yes ☐No ☐Cannot Divulge
9. Do you know of any information that may be a discredit to this person? ..... ☐Yes ☐No ☐Cannot Divulge
10. Do your files indicate any derogatory information whatsoever? ..... ☐Yes ☐No ☐Cannot Divulge

REMARKS_____

_____

_____ _____
Date Signature

_____
Title

BOARD SEAL

_____
Name and address of licensing agency

NOTE TO BOARD COMPLETING THIS FORM: If answer to 1 or 2 is "No", or 3 through 10 is "Yes", explain and attach certified copies of pertinent material (i.e., Notice of Hearing, Final Decision, Consent Order/Agreement, etc.).

(REV. 020201)

Louisiana State Board of Medical Examiners
P. O, Box 30250, New Orleans, LA 70190-0250
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REQUEST FOR EXAMINATION RESULTS

Applicant: Contact examination entity to determine monies necessary to request scores. See "Examination Contacts" in the LSBME application instructions. Complete Sections 1 and 2 and forward to the examining entity.

Section 1: **To Applicant**: Print you name and address *as it appears on your examination application form*.

Name: _____
(Last) (First) (Middle)

Address: _____
(Number & Street) (Apartment Number)

_____
(City) (State) (Zip Code + 4)

Social Security Number: _____ - _____ - _____

Section 2: **To the Examination Entity from Applicant:**

Gentlemen:
I am applying for licensure/reinstatement/re-licensure to practice in Louisiana. This is your authorization to release my examination results (on file and future examination results), favorable or otherwise, to the Louisiana State Board of Medical Examiners. ***See Section 3 below.***

_____ _____
(Signature) (Date)

Section 3: **To Examination Entity**:

Mail examination results to: **Louisiana State Board of Medical Examiners, Licensure Division, P. O. Box 30250, New Orleans, LA 70190-0250**. **DO NOT mail to Applicant**. The LSBME will NOT accept this information from any source other than the examination entity.

(Rev.11/02/00)

Louisiana State Board of Medical Examiners
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Website: **www.lsbme.louisiana.gov**

VERIFICATION OF CREDENTIALS

The LSBME will NOT accept verification from any source other than the Credentialing Board.

Occupational Therapists: Access NBCOT's web site http://www.nbcot.org/verification_orderform.htm for their Verification of Certification Request form.
Respiratory Therapists: Access NBRC's web site http://www.nbrc.org/Credform.htm for their Verification of Credentials form.

Section 1: **To the applicant:** Complete Sections 1 & 2 then forward this form to the Board to which you have received Board Credentials.

_____ _____
Name of Credentialing Board Applicant's Full Name

_____ _____
Street Address City, State and Zip Code plus 4

Section 2: **To the Credentialing Board from the applicant:**
Gentlemen:
I am applying for licensure/reinstatement/re-licensure to practice in the State of Louisiana. This is your authorization to release any information in your files concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

_____ _____
Print or Type your Full Name Signature

_____ _____
Street Address City, State and Zip Code plus 4

_____
Date of credentialing

Section 3: **To the Credentialing Board:** Mail verification of credentials to: Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT return to applicant. The LSBME will NOT accept verification from any source other that the Credentialing Board.

Re: _____

Please certify that the records of the Board indicate the following regarding the above referenced applicant:

- Credential Number
- Type of credential
- Date of credentialing
- Date of examination (if examination taken for credentialing)
- Date credentialing valid through
- Date of re-credentialing
- Date of examination (if examination taken for re-credentialing)
- Date re- credentialing valid through

Louisiana State Board of Medical Examiners

630 Camp Street, New Orleans, LA 70130
(504) 568-6820
Website: www.lsbme.louisiana.gov

VERIFICATION OF SUPERVISION
FOR
NEW OT/OTA GRADUATES AND COTA's

Occupational Therapy Assistants and Occupational Therapy NEW GRADUATES must have a supervisor's signature in order to receive a temporary permit at the time of your personal appearance.

This form must be completed by anyone licensed in this State as an Occupational Therapy Assistant (OTA), **before**

- practicing in Louisiana;
- renewal of OTA license or
- changing supervisor

By signing this document, I hereby certify to the Louisiana State Board of Medical Examiners that I will be working under the supervision of a Certified Occupational Therapist who is registered and who is licensed to practice in Louisiana.

PRINTED Name of Supervising OTR: _____ LA License #: _____

Signature of Supervising OTR: _____ Date: _____

Name and address of Employment:

_____

_____

_____

Telephone # of Employment:

_____

PRINTED Name of OTA/OT/COTA: _____ LA License #: _____

Signature of OTA/OT/COTA: _____ Date: _____

Louisiana State Board of Medical Examiners
630 Camp Street, New Orleans, LA 70130
(504) 568-6820
Website: **www.lsbme.louisiana.gov**

VERIFICATION OF SUPERVISION
FOR
ATHLETIC TRAINERS [Temporary Permit Applicants]

Athletic Trainers must have a supervisor's signature in order to receive a temporary permit at the time of your personal appearance.

This form must be completed by anyone licensed in this State as an Athletic Trainer (ATH), **before**

- practicing in Louisiana;
- changing supervisor

By signing this document, I hereby certify to the Louisiana State Board of Medical Examiners that I will be working under the supervision of a Licensed Athletic Trainer who is registered and is licensed to practice in Louisiana.

PRINTED Name of Supervising ATH: _____ LA License #: _____

Signature of Supervising ATH: _____ Date: _____

Name and address of Employment:

_____

_____

_____

Telephone # of Employment:

_____

PRINTED Name of ATH applicant: _____

Signature of ATH applicant: _____ Date: _____